Washington State Employment Security Department
Shared Work Compensation Plan Application

1. Company Information	**(Company Information Continued)**
Name: _____	Phone number: _____Extension: _____
Mailing Address: _____	Fax number: _____
City: _____ State: _____Zip Code: _____	Email: _____
	2. Employment Security (ES) Tax Reference Number:
Physical Location Address (if different from mailing address):	_____
_____	**Unified Business Identifier (UBI) Number:**
City: _____State: _____Zip Code: _____	_____

3. Your company must designate an Employer Representative responsible for being the contact and coordinating with the Shared Work Administrative Unit. Please write this information below.

Name: _____ Job Title: _____Email: _____

Phone Number: _____ Extension: _____Fax Number: _____

4. Alternate Employer Representative information:

Name: _____ Job Title: _____Email: _____

Phone Number: _____ Extension: _____Fax Number: _____

5. Have you ever had a previous Shared Work plan? Yes_____ No_____
6. When do you anticipate reducing weekly work hours? _____
7. **Employer Certification; I certify to the following:**
   A. The plan identifies the departments, units, sections, and shift(s) to which it applies, and all of the affected employees are full-time (40 hours a week) workers.
   B. The total reduction in work hours is in lieu of temporary layoffs, which would have affected at least ten percent of the employees in the departments, units, sections, shift (s), identified in the plan application.
   C. Health benefits will continue to be maintained in full while hours are reduced.
   D. Any corporate officer for whom participation in the Shared Work Program is being requested, must present verification of full-time employment and must have elected voluntary coverage under RCW 50.04.165.
   E. All reports and information necessary for the proper administration of the plan must be furnished to the Shared Work Administrative Unit.

8. Modification Statement: Authorization to modify the Shared Work plan allows the employer to adjust the hours of work for the participating employees or any other condition, as long as the changes meet the requirements of the original approved plan. Yes _____ No _____

9. Employer Signature: _____Title: _____Date: _____

10. Collective Bargaining agent information (if applicable):

Name: _____Signature: _____Union: _____Local: _____